INSTRUCTIONS FOR COMPLETION OF HOSPICE ELECTION FORM 165

Policy: The completion of this form is required by all hospice providers for all Medicaid recipient's who are determined to be terminally ill based upon AMA guidelines and elect the hospice benefit. This includes new elections, transfers from one hospice to another hospice, and transitions from home to a nursing home for those individual's that are dually eligible. This form should be completed in ink. Once the form has been signed by the physician it should not be altered**.**

1. **PATIENT'S NAME AND PHONE NUMBER:** Record the recipient's name just as it is on the Medicaid card and a telephone number if applicable.

2. **MEDICAID NUMBER:** Record the recipient's 13 digit Medicaid number just as it is listed on the Medicaid card.

3. **HOSPICE NAME:** Record the name of the hospice agency who is providing the care.

4. **PROVIDER NUMBER:** Record the eight digit Medicaid assigned provider number. This number begins with PIC and ends with an E.

5. **PROVIDER PHONE NUMBER:** Record the phone number for the agency providing the care.

6. **DATE:** Record the date of the effective hospice benefit. This should be equivalent to your first billable service date.

7. **ADMITTING DIAGNOSIS CODE(S):** Record the ICD 9 Code of the recipient's terminal illness diagnosis.

8. **CHECK BOXES:** Place a check mark in the applicable box as pertaining to the recipient.

    - The first box indicates that the recipient has Medicare Part A benefits.
    - The second box indicates that the recipient does not have Medicare Part A benefits but must notify the hospice agency of any future eligibility.
    - The third box indicates if the recipient is receiving care in a nursing home and if the recipient is eligible for the room and board benefits.

9. **PATIENT'S SIGNATURE OR MARK:** The recipient signature or representative signature indicates the desire to elect the hospice benefit. The signature must be dated by the individual signing.

10. **PATIENT REPRESENTATIVE SIGNATURE:** If the patient is unable to sign the form he or she may designate a representative to sign. The signature of the representative must be dated by the person signing as the representative.

11. **RELATIONSHIP TO PATIENT:** The relationship of the patient representative should be recorded. Examples include son, daughter, spouse, and significant other.

12. **BENEFIT PERIOD ONE DATE:** The physician making the certification of the terminal illness should record the date of his or her signature and the signature in the corresponding location. If no verbal order is received, this date must be obtained within two days from the effective date noted on Item Number 6. An exception would be for the individual in the community transitioning to a nursing home.

13. **BENEFIT PERIOD TWO DATE:** The physician making the recertification of the terminal illness should record the date of his or her signature. The date should be within two days of the ninetieth day of the first benefit period end date. The signature of the physician should be recorded on the corresponding line.

14, 15, & 16. **VERBAL ORDER DOCUMENTATION:** A verbal order for care may be received for the initial certification only. In the event that a physician verbal order is obtained the Nurse receiving the verbal order must date and sign indicating this receipt and record the physician's name giving this order. If a verbal order is given the physician must certify the election within eight days of this date in number fourteen.